



MEDICAL STATEMENT Participant Record (Confidential Information)

Please read carefully before signing:

This is a statement in which you are informed of some potential risks involved in scuba diving and of the conduct required of you during the scuba training program.

by _____ Instructor/ Facility

located in _____

Read this statement prior to signing it. You must complete this Medical Statement, which includes the medical questionnaire section, to enroll in the scuba training program.

Diving is an exciting and demanding activity. When performed correctly, applying correct techniques, it is relatively safe. When

established safety procedures are not followed, however, there are increased risks.

To scuba dive safely, you should not be extremely overweight or out of condition. Diving can be strenuous under certain conditions. Your respiratory and circulatory systems must be in good health.

If you have any additional questions regarding this Medical Statement or the Medical Questionnaire section, review them with your instructor before signing.

Divers Medical Questionnaire

To the Participant:

The purpose of this Medical Questionnaire is to find out if you should be examined by your doctor before participating in recreational diver training.

Please answer the following questions on your past or present medical history with a YES or NO. If you are not sure, answer YES.

- Could you be pregnant, or are you attempting to become pregnant?
Are you presently taking prescription medications?
Are you over 45 years of age and can answer YES to one or more of the following?
currently smoke a pipe, cigars or cigarettes
have a high cholesterol level
have a family history of heart attack or stroke
are currently receiving medical care
high blood pressure
diabetes mellitus, even if controlled by diet alone

- Dysentery or dehydration requiring medical intervention?
Any dive accidents or decompression sickness?
Inability to perform moderate exercise (example: walk 1.6 km/one mile within 12 mins.)?
Head injury with loss of consciousness in the past five years?
Recurrent back problems?
Back or spinal surgery?
Diabetes?
Back, arm or leg problems following surgery, injury or fracture?

Have you ever had or do you currently have...

- Asthma, or wheezing with breathing, or wheezing with exercise?
Frequent or severe attacks of hayfever or allergy?
Frequent colds, sinusitis or bronchitis?
Any form of lung disease?
Pneumothorax (collapsed lung)?
Other chest disease or chest surgery?
Behavioral health, mental or psychological problems (Panic attack, fear of closed or open spaces)?
Epilepsy, seizures, convulsions or take medications to prevent them?
Recurring complicated migraine headaches or take medications to prevent them?
Blackouts or fainting (full/partial loss of consciousness)?
Frequent or severe suffering from motion sickness (seasick, carsick, etc.)?

- High blood pressure or take medicine to control blood pressure?
Heart disease?
Heart attack?
Angina, heart surgery or blood vessel surgery?
Sinus surgery?
Ear disease or surgery, hearing loss or problems with balance?
Recurrent ear problems?
Bleeding or other blood disorders?
Hernia?
Ulcers or ulcer surgery?
A colostomy or ileostomy?
Recreational drug use or treatment for, or alcoholism in the past five years?

The information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition.

Signature Date Signature of Parent or Guardian Date

STUDENT

Please print legibly.

Name _____ Birth Date _____
First Initial Last Day/Month/Year

Mailing Address _____

City _____ State/Province/Region _____

Country _____ Zip/Postal Code _____

Home Phone () _____ Business Phone () _____

Email _____ FAX _____

Name and address of your family physician

Physician _____ Clinic/Hospital _____

Address _____

Date of last physical examination _____

Name of examiner _____ Clinic/Hospital _____

Address _____

Phone () _____ Email _____

Were you ever required to have a physical for diving? Yes No If so, when? _____

PHYSICIAN

This person applying for training or is presently certified to engage in scuba (self-contained underwater breathing apparatus) diving. Your opinion of the applicant's medical fitness for scuba diving is requested. There are guidelines attached for your information and reference.

Physician's Impression

- I find no medical conditions that I consider incompatible with
 diving. I am unable to recommend this individual for diving.

Remarks

Physician's Signature or Legal Representative of Medical Practitioner Date
onth/Year Day/M

Physician _____ Clinic/Hospital _____

Address _____

Phone () _____ Email _____